

### C. AUTHORIZATION OF REIMBURSEMENT FOR SERVICES

All authorization requirements in this section must be completed for all clients even if the services will be funded by a source other than Medi-Cal, such as SB90.

#### AUTHORIZING OUTPATIENT SERVICES

The San Diego County MHP defines Children's Mental Health clients as children and youth under 18 years of age. At times young adults may be served if they are receiving services pursuant to AB 2726 or if continuing in a CMHS program is clinically indicated. Clients may access the services of organizational providers and county-operated facilities in the following ways:

- Calling the organizational provider or county-operated program directly
- Walking into an organizational provider or county-operated program directly
- Calling the Access and Crisis Line at 1-800-479-3339

If a client first accesses services by calling or walking into an organizational provider or county-operated program, the client can be seen and assessed without contacting UBH for an authorization. The provider does not need to call UBH or send/fax an assessment or contact sheet.

When the provider conducts an assessment of a client who has called or walked into the program, that provider is responsible for entering administrative and clinical information into all the appropriate fields in InSyst. Providers must register clients, record episode and service activities, and update the CIS information in InSyst. See the Management Information Systems section of this handbook for a description of how InSyst supports these provider activities.

If the Access and Crisis Line refers a client to an organizational provider or to a county-operated facility, an authorization letter will be sent to the provider. The ACL opens a record in eCura (a computerized client data system) for each client it refers to an organizational provider or a county-operated program; if the client is new, he or she will be concurrently registered in InSyst. The provider's program staff is then responsible for insuring the client information is complete, including the client address and significant other information. Staff is also responsible for recording all ongoing activity for that client into InSyst. This information includes, but is not limited to, episode and service activities, the primary diagnosis, the name of the primary clinician, and all client episode closings.

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### Medical Necessity for Outpatient Services

Authorization is performed through the MHP Utilization Management Process, using Title 9 (Section 1830.205) Medical Necessity criteria as summarized below. A complete description of Title 9, Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services can be found on the State website at [www.calregs.com](http://www.calregs.com). For a copy of Title 9, please call the State Office of Administrative Law at 916-323-6225. Services provided to clients by outpatient providers are reimbursed if the following medical necessity criteria are met and authorization via UR, if required, is in place:

- The client must have a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) that is reimbursable for outpatient services as described in Title 9, Section 1830.205 (1).

AND

The client must have at least one of the following as a result of the mental disorder(s):

- A significant impairment in an important area of life functioning; or
- A probability of significant deterioration in an important area of life functioning.
- A probability that the client will not progress developmentally as is individually appropriate (for Medi-Cal beneficiaries under age 21).

AND

All of the following:

- The focus of proposed intervention is to address the impairment or potential impairment identified immediately above.
- The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning.
- The condition would not be responsive to physical healthcare treatment.\

### Seriously Emotionally Disturbed (SED) Clients

The priority population for Children's Mental Health Services, including clients seen under the Mental Health Services Act, are seriously emotionally disturbed (SED) children and youth. SED clients must meet the criteria for medical necessity and further are defined as follows per California Welfare & Institutions Code Section 5600.3.:

For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the

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child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas:

- \* self-care,
- \* school functioning,
- \* family relationships,
- \* or ability to function in the community;

and either of the following occur:

- (i) The child is at risk of removal from home or has already been removed from the home.
- (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Note from CMHS: **AB2726 CLIENTS MAY NOT BE SEEN UNDER THE MHSA.**

## UTILIZATION REVIEW

The MHP has delegated responsibility to County operated and contracted organizational providers to perform utilization management for specialty mental health services, crisis stabilization services, outpatient services, medication services, and case management services. Authorization decisions are based on the medical necessity criteria delineated in Title 9 of the California Code of Regulations. Each delegated entity shall be accountable to the Children's Mental Health Director and shall follow the Utilization Review processes established for children's mental health programs.

For outpatient programs, a UR Committee shall review all outpatient clients' cases (except medication only cases) if the case is still open six (6) months after intake. If client is concurrently in day treatment and outpatient services, then UR authorization must occur through day treatment and United Behavioral Health (UBH) because the day treatment cycle supersedes outpatient UR. Please refer to the Guidelines for Outpatient Utilization Review in Section F of this Handbook. However, if the client is terminated from the Day Program they shall revert to the cycle for outpatient UR that requires a review by six (6) months, based on the first planned service in the current treatment episode. If the first six (6) months have passed, the

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case shall be reviewed at the next UR meeting, not to exceed thirty (30) days from termination from the day program.

Utilization management of children's inpatient services is delegated to Telecare and utilization management of day intensive and day rehabilitation services is delegated to UBH. Authorization management for Therapeutic Behavioral Services is retained by the MHP.

### Utilization Management Activities Delegated to Organizational Providers

#### *Initial Assessment*

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria for specialty mental health services. The clinician shall complete the County's MHS 650 Assessment Form or its successor and ensure that all required domains are completed.

The MHS 650 Assessment, the Service Plan, and progress notes will be reviewed during County and State medical record reviews with respect to whether medical necessity has been documented.

#### *Utilization Review Committee*

The Utilization Review Committee operates at the program level and must include at least one licensed or waived clinician. The Utilization Review Committee bases its decisions on whether medical necessity is still present in the client *and* whether the proposed services are likely to assist in meeting the service plan goals. To assist in its determination, the Utilization Review Committee or clinician receives a Request for Utilization Review form (which reports current client functioning in quadrants for various domains) and a new Service Plan to cover the interval for which authorization is requested. Medication only clients are currently not included in the Utilization Review process.

### SPECIFIC PROCEDURES AND CRITERIA FOR NON-HOSPITAL CARE LEVELS

The following are specific procedures and criteria for each level of care:

#### **Outpatient Providers**

The assessment and service plan must be completed within 30 days of admission into the program. If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the client will be issued an NOA-A and their beneficiary rights shall be explained. If a client will receive day treatment services (either intensive or rehabilitative) on the same day that the client receives Mental Health Services

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(Individual, Group, or Collateral), authorization for the Mental Health Service must be obtained from United Behavioral Health through the day treatment provider.

### Day Rehabilitation and Day Intensive

Prior to admission to the program, each client must have a face-to-face assessment to establish medical necessity. The assessment must document that a recommendation for day program was made in the course of a formal assessment, lower levels of care have been tried unsuccessfully or would be unsuccessful if attempted, and a highly structured mental health program is needed to prevent admission to a more intensive level of care.

The Initial Day Program Request must be submitted along with: recent program assessment, copy of client face sheet from InSyst, and a Specialty Mental Health Services DPR if the client receives ancillary services on the same day as day program services. Continued Requests that are made must be accompanied with client face sheet and a Specialty Mental Health Service DPR if applicable. Utilization review will be completed by United Behavioral Health according to necessity criteria for the level of day service.

These service criteria essentially state that the client cannot be served at a lower level of care and that a recommendation for day services has been made. Day treatment services must be reauthorized every 3 months for day intensive and every 6 months for day rehabilitative. If medical or service necessity criteria are not met, the client will be issued an NOA-A and the beneficiary rights shall be explained. In the event that the provider has received a denial of authorization from United Behavioral Health, an NOA-B shall be issued.

When the day treatment services are provided out of county, an alternative Day Program Request Form may be used if it contains all required elements. Approval for its use is to be obtained by either the Program Monitor or Chief of Quality Improvement.

### Therapeutic Behavioral Services

Prior to approval for services, the referred client must be assessed for eligibility criteria according to California Department of Mental Health guidelines provided in DMH Letter 99-03 and DMH Notice 02-08. The County of San Diego conducts this assessment, and eligible clients are referred to a contract provider. If class, service, or other TBS Criteria are not met, the client will be issued an NOA-A and their beneficiary rights shall be explained. A record of this action shall be documented in the NOA Log. Qualifying clients receive an initial authorization of services for 30 days or 60 hours, whichever occurs first. This initial authorization allows the contract provider to complete a behavioral assessment and TBS treatment plan, and to provide initial services. Additional payment/service reauthorizations are requested by the contract provider and are authorized by the County for 60 hours or 120 days, whichever occurs first. If a reauthorization request is modified or denied by the County, the client will be issued an NOA-B and their beneficiary rights shall be explained. A record of this action shall be documented in the NOA log.

### BENEFICIARY RIGHTS

#### *Client Grievances and Appeals*

Clients in the MHP shall be informed, in a clear and concise manner, about the process for reporting and grievances and appeals related to MHP services. Consistent with the principle of a consumer driven system of care, the consumer Grievance and Appeal Process has been developed through a collaborative process and has been approved by the California Department of Mental Health.

#### **Notices of Action (NOA)**

Each delegated entity shall maintain an NOA Log (Section O, Attachment 4) and document actions as described below.

- 1) When providers have assessed a client and determined that he or she does not meet Title 9 medical necessity criteria for specialty mental health services, the provider shall give the client a *Notice of Action-Assessment (NOA-A) Form* (Section O, Attachment 5). The client is then to be referred to appropriate services in the community. A record of this action shall be documented in the NOA Log.
- 2) When the United Behavioral Health or another formal utilization reviewer reduces, modifies, or terminates a client's services, the clinician and the client shall receive an *NOA-B Form (Section O, Attachment 6)*. A record of this action shall be entered in the NOA Log. If services are to be terminated, a psychiatrist review is required prior to termination.
- 3) The client shall be notified of his/her right to a second opinion and the right to request a State Fair Hearing at any time.

#### **QI Program Monitoring**

The MHS Children's Quality Improvement Unit shall monitor each organizational provider's compliance with these requirements, to assure that activities are conducted in accordance with both State and MHP standards. If the delegated entity's activities are found not to be in compliance, the MHP shall require that a corrective action plan be formulated. Progress toward change will be effected through direct management, in the case of a County operated program or through contract monitoring in the case of a contractor. The Quality Improvement Unit will prioritize and discuss opportunities for improvement with any provider having performance problems. Corrective action plans shall be monitored for implementation and appropriateness as deemed necessary, between annual reviews. If the provider does not successfully correct the problems within the stated timeframe, the County will take appropriate remedial action.

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#### Medi-Cal Funded Child and Adolescent Inpatient Services

Fee for service inpatient service providers must notify the County at the time of admission. The FFS inpatient providers must fax a Crisis Notification form with pertinent demographic and clinical information to the Emergency Screening Unit (ESU) within 10 days. The fax number is 619-421-7186. Notification can be made by phone but faxing is the preferred method. If phoning, call 619-421-6900 and request to speak to an intake worker. The ESU intake worker will fill out a Crisis Notification form.

- All Medi-Cal and unfunded admissions to UCSD-CAPS are screened and authorized by the ESU.
- The Crisis Notification form is faxed by ESU to Telecare for notification of a Medi-Cal admission.
- The Crisis Notification form is faxed by ESU to appropriate program for possibility of case management services during and following the hospitalization.
- The MHP delegates to Telecare the responsibility of payment authorization. This includes initial review of medical records to evaluate medical necessity according to Title 9 regulations and retrospective payment authorization on all discharge records. Telecare also reviews all potential provider payment denials and appeals.

#### Realignment Funded Child and Adolescent Inpatient Services

Clients without Medi-Cal eligibility or the means or resources to pay for inpatient services are eligible for realignment funded services and are referred to the ESU at 619-421-6900, 730 Medical Center Ct., Chula Vista, CA 91911.

#### Medical Necessity for Child and Adolescent Inpatient Services

Inpatient services for Medi-Cal beneficiaries are reimbursed by the MHP only when the following criteria are met, as outlined in Title 9, Section 1820.205.

- The client must have a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) that is reimbursable for inpatient services as described in Title 9, Section 1820.205 (1).

AND

Both of the following:

- The condition cannot be safely treated at a lower level of care;
- Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 or 2 below:

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1. The symptoms or behaviors:

- a. Represent a current danger to self or others, or significant property destruction;
- b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;
- c. Present a severe risk to the beneficiary's physical health;
- d. Represent a recent, significant deterioration in ability to function.

OR

2. The symptoms or behaviors require one of the following:

- a. Further psychiatric evaluation; or
- b. Medication treatment; or
- c. Other treatment that can reasonably be provided only if the patient is hospitalized.

### Coordination of Care

Coordination of care among inpatient and outpatient services is essential for a mental health system to work efficiently. It also supports the clients' efforts to achieve and maintain the highest possible level of stability and independence. The MHP monitors coordination of care.

Chart reviews are conducted at all levels of services. Inpatient reviews include retrospective review of documentation to confirm that clients were referred to an outpatient program or psychiatrist or other licensed mental healthcare provider upon discharge. Contact with the client's primary service provider must be documented in the chart. A Client Satisfaction Survey is administered to all clients at discharge from an acute inpatient facility.

If the client has recently been discharged from an inpatient facility, or is transferring from a previous outpatient provider, organizational providers and county-operated programs are expected to obtain a signed Release of Information (ROI) from the client or legal representative in order to obtain relevant mental health information.

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